

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 009894	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/15/2015
NAME OF PROVIDER OR SUPPLIER BERKSHIRE OF CASTLETON		STREET ADDRESS, CITY, STATE, ZIP CODE 8480 CRAIG ST INDIANAPOLIS, IN 46250		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit to the State Residential Licensure survey completed on March 5, 2015.</p> <p>Survey date: April 14, 2015</p> <p>Facility number: 009894 Provider number: 009894 AIM number: N/A</p> <p>Census bed type: Residential : 120 Total : 120</p> <p>Census payor type: Other : 120 Total : 120</p> <p>Sample 10</p> <p>Berkshire of Castleton was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the State Residential Licensure Survey.</p> <p>Quality Review was completed by Tammy Alley RN on April 20, 2015.</p>	{R 000}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE